WISCONSIN MEDICAL ASSISTANCE PROGRAM

HEALTHCHECK (EPSDT) SCREENING SERVICES HANDBOOK

PART D, DIVISION I

PART D, DIVISION I
HEALTHCHECK SCREENING SERVICES PROVIDER HANDBOOK
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part D, Division I, of the handbook will be numbered sequentially. This sequential numbering system will alert the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log will help eliminate errors and ensure an up-to-date handbook.

If you are missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 1D-3 and you receive 1D-5, you are missing 1D-4. If the provider is missing a transmittal, copies of complete provider handbooks may be obtained by completing the order form in Appendix 36 of the WMAP Part A Provider Handbook.

Transmittal Number	Initials	Issue Date
1D-1		03/92
1D-2		06/92
1D-3		11/92
1D-4		12/92
1D-5		10/94
1D-6		02/95
1D-7		05/95

Transmittal Number	Initials	Issue Date

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Chapters HSS 101-108 and by state and federal law. These regulations are interpreted for provider use in two WMAP provider handbooks. The two handbooks are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific handbook at the time of certification.

Additional copies of provider handbooks may be obtained by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental, etc.).

It is important that both the provider of service and the provider's billing personnel read this material prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales.

Providers should also be aware of other documents including state and federal laws and regulations, relating to the WMAP.

1. Chapter 49.43 - 49.497, Wisconsin Statutes

2. Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and the abbreviations appears in Appendix 30 of the Part A handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

HEALTHCHECK SCREENING SERVICES
TABLE OF CONTENTS

A. TYPE OF HANDBOOK

The HealthCheck Screening Services Handbook, Part D, Division I is the service specific portion of the Wisconsin Medical Assistance Provider Handbook. Part D, Division I includes information applicable to HealthCheck screening providers. The intent of this handbook is to provide information regarding provider eligibility criteria, covered services, reimbursement, and billing instructions for the HealthCheck program. The handbook should be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

How to Use This Handbook
This handbook is intended to:

1. Explain how the HealthCheck screening examination fits into the overall HealthCheck program.

2. Provide medical practitioners with all information needed to perform an effective, reimbursable WMAP HealthCheck screening examination.

3. Provide complete information on billing the WMAP.

Scope of Service
The policies in Part D, Division I govern all HealthCheck services provided within the scope of professional practice as defined in Chapter 49, Wis. Stats. and Wis. Adm. Code Chapter HSS 105. Covered services and related limitations are enumerated in Section II of this handbook.

Overview of the HealthCheck Program
HealthCheck is the WMAP's federally mandated program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (see Federal Regulation 42CFR, Part 441). HealthCheck consists of a comprehensive screening of WMAP recipients under the age of 21. The screening includes review of growth and development, identification of potential physical or developmental problems, preventive health education, and referral assistance to appropriate providers of service. HealthCheck also includes targeted outreach and case management services to "at-risk" children, to ensure that these children have access to needed medical, social and educational services. A detailed description of screening components is provided in Section II of this handbook. Information on HealthCheck outreach and case management services is contained in Part D, Division II.

The HealthCheck program involves three distinct activities:

1. Identifying recipients who are <u>not receiving</u> preventive care from <u>either</u> physicians or non-physician screeners.

2. Seeking recipients who are "at risk", educating them on matters of health, and helping them establish a relationship with a healthcare provider. HealthCheck outreach and case management are described in detail in Part D, Division II of the handbook, which is sent only to certified case management providers.

3. Providing HealthCheck screenings, assessments and referrals.

A. TYPE OF HANDBOOK (continued)

HealthCheck screening examinations may be distinguished from other preventive health care under the WMAP because:

1. HealthCheck includes a strong anticipatory guidance and health education component, a schedule for periodic examinations (based on recommendations by organizations that are recognized as authorities in the field of child and adolescent health), detailed documentation for necessary follow-up care, and increased provider involvement for ensuring that the recipient is appropriately referred for care.

2. HealthCheck screenings qualify Medical Assistance recipients under age 21 for certain benefits not otherwise covered by the WMAP (e.g., orthodontia treatment) and "Other Services". Refer to Section II-F of this handbook for additional information on "Other Services".

B. PROVIDER INFORMATION

Provider Eligibility and Certification

Wisconsin Administrative Code, Chapter HSS 105.37(1)(a) defines the following types of providers and agencies as eligible for HealthCheck screener certification:

1. Physicians;
2. Outpatient hospital facilities;
3. Health maintenance organizations;
4. Visiting nurse associations;
5. Local public health agencies;
6. Home health agencies;
7. Rural health clinics;
8. Indian health agencies;
9. Neighborhood health centers;
10. Nurse practitioners; and
11. Clinics operated under a physician's supervision.

Eligible providers who wish to become certified as a HealthCheck screener must submit their request in writing to:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

HealthCheck screening services must be performed by or under the supervision of skilled medical personnel within their scope of practice as allowed by state and federal law. Skilled medical personnel are:

1. Physicians (M.D. or D.O.)
2. Physician's Assistants
3. Nurse Practitioners
4. Public Health Nurses
5. Registered Nurses

Skilled medical personnel who perform physical assessment screening procedures must have successfully completed either a pediatric assessment or inservice training course on physical assessments that has been approved by the Department of Health and Social Services (DHSS). Paraprofessional staff may provide other individual components of a HealthCheck screening (excluding the physical assessment) if they are supervised by skilled medical personnel.

B. **PROVIDER INFORMATION** (continued)

Questions regarding HealthCheck clinical requirements may be directed to:

Bureau of Health Care Financing
Attn: HealthCheck Coordinator
Post Office Box 309
Madison, WI 53701-0309

Certification for Laboratory Services

All laboratories which test human specimens to determine health status are covered by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. CLIA governs every aspect of laboratory operation, including tests performed, personnel qualifications, quality control, quality assurance, proficiency testing, patient test management, and records and information systems. Every provider that performs laboratory tests must obtain a CLIA identification number and a certificate of waiver or a certificate of registration from the Health Care Financing Administration (HCFA). This applies to clinics and individual provider offices that perform laboratory tests.

Clinics with laboratories with more than one location must have a WMAP billing provider number for every laboratory which has a CLIA identification number in order to receive the correct reimbursement for laboratory services.

A laboratory may qualify for a certificate of waiver if it restricts its testing to the eight specific tests identified by HCFA as waived tests.. A laboratory performing other than waived tests is issued a certificate of registration.

If you refer specimens to an outside lab for testing, you may be reimbursed for a lab handling fee as described in Section IV of this handbook. However, the referral lab must be certified by the WMAP and must bill separately for the service in order for the service to be reimbursed.

Reimbursement for laboratory services is limited to procedures for which the performing laboratory has a valid CLIA certificate of registration or certificate of waiver in effect for the date of service.

Reimbursement

In recognition of the importance of comprehensive child health care, payment for HealthCheck screenings is at a higher rate than for other preventive exams such as "well baby" and "well child". Reimbursement for HealthCheck screening services is made in accordance with a maximum allowable fee schedule established by the DHSS. This payment schedule is based upon a variety of factors including usual and customary charges for similar types of services billed by non-screener physicians, costs generally incurred in obtaining immunization biologicals, and the Wisconsin State Legislature's budgetary constraints. In all cases, HealthCheck screeners will be reimbursed the lesser of the provider's usual and customary charge (the amount charged to non-Medical Assistance recipients for the same service) or the maximum allowable fee.

Maximum allowable fees exist for the comprehensive screening package for vision screens, hearing screens, and dental screens. Laboratory tests, immunizations, and pelvic exams should be billed additionally. In most situations, a comprehensive screen is performed. However, if a comprehensive screen is not appropriate, individual screens may be provided. (Detailed information on screening components and proper billing can be found in Sections II and IV of this handbook.)

B. PROVIDER INFORMATION (continued)

Reimbursement for vaccines provided through the Vaccines for Children Program (VFC) is limited to an administration fee, since the vaccines are provided free to providers who give immunizations. Refer to Section II-L and Appendix 1 of this handbook for information on the VFC, and to Sections II-C and IV-F for information on billing for vaccines.

Copies of the HealthCheck Maximum Allowable Fee Schedule may be purchased as indicated in Appendix 3 of the WMAP Part A Provider Handbook.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Section IV of the WMAP Part A Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

HealthCheck screening provider responsibilities include the following clinical and administrative activities.

1. Clinical activities include:

   a. performing all applicable screen components in a manner consistent with contemporary clinical practice.

   b. providing anticipatory guidance and health education, including nutrition evaluation and counseling, explanation of screening results and the importance of periodic HealthCheck exams, including the scheduling of next HealthCheck exam.

   c. documenting the screening tests performed and referrals made and billing the WMAP for these services in accordance with the guidelines presented in this handbook.

   d. giving the recipient a HealthCheck Verification Card or HealthCheck Referral Form as needed, for use as proof of screening so that the recipient can obtain certain services that are not usually covered by the WMAP (e.g., dental sealants).

   e. referring the recipient for an annual dental examination if a recipient over three years of age is not regularly receiving dental care.

   f. referring the recipient for any needed care that is not provided at the time of screening. If the recipient is in the Primary Provider Program, rules for the Primary Provider Program must be followed.

   g. reporting to the Center for Health Statistics, at the address listed below, any birth defect, adverse neonatal outcome, or developmental or other severe disability that is diagnosed or suspected as a result of a HealthCheck screening, pursuant to ch. HSS 116, Wis. Admin. Code.

      Center for Health Statistics
      Birth and Developmental
      Outcome Monitoring Program
      Post Office Box 309
      Madison, WI 53701-0309

B. PROVIDER INFORMATION (continued)

h. maintaining a confidential medical record of any service provided and all test results for each patient who receives a HealthCheck screening examination (HSS 105.37[1][c]b., Wis. Admin. Code). This record must include all information upon which claims for HealthCheck payment is based, including adequate documentation in the medical record that all the components of the screen have been completed).

2. Administrative activities include:

a. including, as applicable, the following written documentation in the recipient's medical record as stated in HSS 106.02 (9) (b), Wis. Admin. Code:

- Date, department or office of the provider, as applicable, and provider name and profession;
- Chief medical complaint or purpose of the service or services;
- Clinical findings;
- Diagnosis or medical impression;
- Studies ordered, such as laboratory or x-ray studies;
- Therapies or other treatments administered;
- Disposition, recommendations and instructions given to the recipient, including any prescriptions and plans of care or treatment provided; and
- Prescriptions, plans of care and any other treatment plans for the recipient received from any other provider.

b. preparing and maintaining truthful, accurate, complete, legible and concise documentation and medical and financial records according to HSS 106.02 (9) (a), Wis. Admin. Code, . In addition to the documentation and recordkeeping requirements specified in HSS 106.02 (9) (b), (c), and (d), Wis. Admin. Code, the provider's documentation, unless otherwise specifically contained in the recipient's medical record, must include:

- The full name of the recipient;
- The identity of the person who provided the service to the recipient;
- An accurate, complete and legible description of each service provided;
- The purpose of and need for the services;
- The quantity, level and supply of service provided;
- The date of service;
- The place where the service was provided; and
- The pertinent financial records.

c. Maintaining the following financial records in written or electronic form as stated in HSS 106.02 (9) (c), Wis. Admin. Code:

B. **PROVIDER INFORMATION** (continued)

- Payroll ledgers, cancelled checks, bank deposit slips and any other accounting records prepared by the provider;
- Billings to Medical Assistance, Medicare, health insurance, or the recipient for all services provided to the recipient;
- Evidence of the provider's usual and customary charges to recipients and to persons or payers who are not recipients;
- The provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;
- Billing claims forms for either manual or electronic billing for all health services provided to the recipient;
- Records showing all persons, corporations, partnerships and entities with an ownership or controlling interest in the provider, as defined in 42 CFR 455.101; and
- Employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous five years. Employee records must include employee name, salary, job qualifications, position description, job title, dates of employment and the employee's current home address or the last known address of any former employee.

d. Maintaining the following according to HSS 106.02 (9) (d), Wis. Admin. Code:

- The provider must maintain documentation of all information received or known by the provider of the recipient's eligibility for services under Medical Assistance, Medicare or any other health care plan, including but not limited to an indemnity health insurance plan, a health maintenance organization, a preferred provider organization, a health insuring organization, or health insurance;
- The provider must retain all evidence of claims for reimbursement, claim denials and adjustments, remittance advice, and settlement or demand billings resulting from claims submitted to Medical Assistance, Medicare, or health insurance; and
- The provider must retain all evidence of prior authorization requests, cost reports and supplemental cost or medical information submitted to Medical Assistance, Medicare and health insurance, including the data, information and other documentation necessary to support the truthfulness, accuracy and completeness of the requests, reports, and supplemental information.

e. Retaining all records of services rendered for a period of not less than five years from the date of payment (HSS 105.02[4], Wis. Admin. Code).

f. complying with all other provider responsibilities cited in HSS 101-108 of the Wisconsin Administrative Code and Section IV of the WMAP Part A Provider Handbook.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care coverage, or Medicare coverage.

Medical Assistance identification cards are sent to recipients on a monthly basis. All cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V-C of the WMAP Part A Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards and how to verify eligibility. Section V-C of Part A must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of the WMAP Part A Provider Handbook.

HealthCheck Program Recipient Eligibility

Any recipient under 21 years of age with a valid current Medical Assistance identification card is eligible for a HealthCheck screening, unless:

1. The recipient is enrolled in a WMAP-contracted managed care program (indicated by a yellow Medical Assistance card). Only the managed care program or its affiliated providers may provide the screening for that recipient.

2. The recipient has recently received a HealthCheck screening. The WMAP does not reimburse providers for comprehensive HealthCheck screenings more frequently than allowed under the HealthCheck Periodicity Schedule (Appendix 5 of this handbook), although interperiodic screens may also be billed. (See Sections II-A and II-D of this handbook.)

Copayment

No copayment may be charged for a HealthCheck screening provided to a recipient under 18 years of age, or to any recipient enrolled in a WMAP-contracted managed care program.

A $1.00 screening copayment must be collected from any recipient between 18 and 21 years of age for comprehensive screenings only. Applicable copayments will be automatically deducted by EDS from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of the recipient copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, and 22a of the WMAP Part A Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

C. **RECIPIENT INFORMATION** (continued)

Medical Assistance recipients enrolled in a WMAP-contracted managed care program are entitled to all of the same HealthCheck benefits outlined in this handbook, including a referral for dental and other medically necessary services (see Section II-F of this handbook for a description of HealthCheck "Other Services"). For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for HealthCheck services are established by the contract between the managed care programs and certified providers.

A. PERIODICITY SCHEDULE

As required by federal regulation (42CFR 441.58), the Wisconsin Medical Assistance Program (WMAP) has established a periodicity schedule for screening services. This schedule specifies the time period when services appropriate at each stage of the recipient's life should be done, beginning with a neonatal examination at birth, up to the 21st birthday. The periodicity schedule closely approximates the American Academy of Pediatrics recommendations and is consistent with reasonable standards of medical and dental practice.

Periodicity Limitations

The periodicity schedule for determining the screening intervals and age appropriate procedures is detailed in Appendix 5 of this handbook. A recipient is limited, based on their age, to the following number of comprehensive screenings for a consecutive 12-month period:

- Birth to first birthday, 6 screenings
- First birthday to second birthday, 3 screenings
- Second birthday to third birthday, 2 screenings
- Third birthday to twenty-first birthday, 1 screening per year

Claims submitted for comprehensive screening packages performed more frequently than the above limits are denied. A comprehensive screening may only be billed if all age-specific components of a screening are performed. This includes a blood pressure reading and oral assessment for recipients three years of age and older. It also includes a measurement of head circumference for infants until their second birthday.

B. COMPONENTS OF A COMPREHENSIVE HEALTHCHECK SCREENING

Required Components for Comprehensive Screens

As specified in HSS 107.22(2) Wis. Admin. Code, to be recognized as a complete screen according to WMAP definition, the provider must assess and document in the child's medical record all of these components:

1. a comprehensive health and developmental history (including anticipatory guidance);
2. a comprehensive unclothed physical examination;
3. an age-appropriate vision screen;
4. an age-appropriate hearing screen;
5. oral assessment and evaluation services plus direct referral to a dentist for children beginning at three years of age;
6. appropriate immunizations; and
7. appropriate laboratory tests.

The WMAP has developed and makes available free of charge forms that meet the documentation requirements of the program listed in this section. Use of these forms is not mandatory. Many clinics/agencies have developed documentation systems which work well for them and are encouraged to continue to do this. It is required that documentation shows that all areas listed in this section have been assessed, and is located in the individual's medical record.

B. COMPONENTS OF A COMPREHENSIVE HEALTHCHECK SCREENING (continued)

Guidelines for Completing Components

1. Health, Nutritional, and Developmental Assessment

a. Health History. A review of the recipient's and family's health and treatment history to identify special risk factors or prior conditions/treatments pertinent to future care. To avoid duplication of services, special attention should be given to recent primary or preventive care services (e.g., immunizations, WIC certifications, nutritional assessment, and questions about lead exposure) that would reduce the need for some HealthCheck screening services. Information obtained through the HealthCheck Individual Health History form (see Appendix 7 of this handbook) and the Family History (Appendix 10 of this handbook) or , other similar information is required. If the HealthCheck Family History form is used, fill it out the first time for each recipient and update it at following visits. In addition, a HealthCheck Adolescent Review form is also available for use (see Appendix 9 of this handbook).

b. Nutritional Assessment
A review of the individual's eating patterns/habits must be included in order to identify persons who may require a more in-depth dietary assessment and counseling, particularly if other nutrition-related risk factors exist (e.g., iron deficiency anemia, abnormal height/weight). The 24-Hour Food Diaries (Appendix 8a of this handbook) may be used. The Modified Basic Food Groups and Daily Suggestions for Infants (Appendices 8b and 8c of this handbook) are guides to determine the serving equivalencies that each food represents. It also shows the total number of suggested servings for each age group.

c. Health Education/Anticipatory Guidance. All screening exams must include preventive health education and an explanation of screening findings. This may include discussion of:

- Proper nutrition, parenting skills, family planning concerns, alcohol and other drug abuse/mental health concerns (see Appendix 16 of this handbook for resource literature).
- Preventive health and healthy lifestyle actions (e.g., use of infant car seats, poison prevention, injury prevention, hot water temperature settings, avoidance of tobacco products).
- Normal stages of growth and development.
- Screening findings and explanation of any problems found and the importance of necessary follow-up care.

d. Developmental Behavioral Assessment. Observed behavior and attainment of developmental milestones (including emotional status) should be compared to age specific norms to identify developmental delays or subtle indications of hidden problems. This component may include use of a developmental screening tool such as the Denver Developmental checklist for children under 6 years of age. Providers may use the HealthCheck Age-Specific Developmental Screening

B. COMPONENTS OF A COMPREHENSIVE HEALTHCHECK SCREENING (continued)

checklists developed by Memee K. Chun, M.D. or other similar age-specific device for assuring that all significant developmental milestones are considered. To obtain the HealthCheck Age-Specific Developmental Screening Checklist, refer to Appendix 16 of this handbook.

Parental concerns and observations regarding the child's development and health should be reviewed to identify possible special conditions warranting more careful examination. When appropriate, confidential review of the recipient's concerns, independent of the parent, may occur, especially with older adolescents (see Appendix 9 of this handbook for the HealthCheck Adolescent Review).

2. Physical Assessment.

a. Unclothed Physical Exam and Physical Growth Assessment. This should be a systematic examination of each body system according to accepted medical procedure. Blood pressure readings must be taken for all children beginning at 3 years of age.

NOTE: The screener should be alert for any indication of physical or sexual abuse. State law requires that signs of abuse be reported immediately to Child Protection Services of your local County Department of Social Services.

b. Growth Assessment. Comparison of recipient's height, weight and head circumference to age specific norms to identify growth abnormalities. This includes the calculation of the child's length to age percentile, weight to length percentile and head circumference to age percentile. Head circumferences to age percentiles should be determined up to age 2. The National Center for Health Statistics (NCHS) growth grids are recommended for use in identifying unusual body size which may be due to disease or poor nutrition. To obtain copies of the NCHS growth grids, refer to Appendix 16 of this handbook.

c. Sexual Development. The Tanner Sex Maturity Ratings is a useful tool for checking sexual development. To obtain copies of the Tanner Sex Maturity Ratings, refer to Appendix 16 of this handbook. Special attention should be given to recipients who have reached puberty.

At the request of the recipient or parent, the screener must provide counseling on sexual development, birth control, and sexually transmitted disease, as well as appropriate prescriptions and testing, or the screener must refer the recipient to an appropriate resource.

A pelvic examination or referral for the appropriate testing should be offered to all females who have reached puberty.

3. Examination of Visual Acuity.
All children should be observed for:

a. appropriate visual acuity
b. strabismus
c. abnormal disc reflex (under age 1 year)
d. response to cover test
e. amblyopia
f. color blindness

B. COMPONENTS OF A COMPREHENSIVE HEALTHCHECK SCREENING (continued)

Use of vision charts must be attempted to measure visual acuity beginning at age 4 years.

4. Screening for Hearing Loss

   a. All hearing screenings in infancy and early childhood should include an otoscopic exam and/or tympanometric measurements for the detection of chronic or recurrent otitis media.

   b. Screen at birth through age 2 using both methods outlined in Appendix 14 and 14a of this handbook. Children failing either screening method should be referred for audiological assessment. Refer to Appendix 16 of this handbook to order copies of "Your Child's Speech and Hearing."

   c. Administer puretone audiometric screening as follows: annually to all children 3-8 and at four-year intervals thereafter up to age 16; and to any children older than age 8 with excessive exposure to noise, delayed speech and language development or who are receiving HealthCheck screening for the first time. (See Appendix 14a of this handbook.)

5. Examination of Oral Health. This exam must be sufficient to identify children in need of early examination by a dental professional. The examination should include questioning the parents of children under age 3 years regarding the presence of problematic thumb sucking, lip biting, caries, tongue thrusting, non-erupted teeth, extra teeth, extended use of pacifier or bottle feeding practices conducive to early dental caries or malfunction of oral cavity. All children aged three or older (and younger where medically indicated) must be referred to a dentist if they are not already receiving such care. Medically necessary services which are not otherwise covered by the WMAP may be covered under HealthCheck "Other Services" (e.g., pit and fissure sealants). Refer to Section III-B of this handbook for information on HealthCheck "Other Services".

   The following dental services are only covered by the WMAP when provided to recipients under age 21 and must be in conjunction with a HealthCheck referral:

   a. Orthodontics (Once started, orthodontic services will be reimbursed to completion regardless of the recipient's eligibility. Prior authorization is required);

   b. Pit and fissure sealants. (Prior authorization is not required);

   c. One additional cleaning per year with prior authorization for children ages 13 through 20. Regular WMAP coverage is one cleaning per year for recipients between the ages of 13 and 20.

   (Refer to Appendix 6 for more detail on effective oral assessment.)

6. Immunization. Federal regulations require that immunizations be given according to the recommendations of the Advisory Committee on Immunization Practice (ACIP) or the American Academy of Pediatrics (AAP) unless medically contraindicated. These recommendations can be found in Appendix 21 of this handbook. Additional information about immunizations can be found in Section II "Vaccines for Children" of this handbook.

B. COMPONENTS OF A COMPREHENSIVE HEALTHCHECK SCREENING (continued)

7. Laboratory Tests. Blood lead test. As a result of a recent federal court settlement, all children ages 6 months to 72 months are considered at risk and must be screened for lead poisoning. Health Care Financing Administration (HCFA) now requires the use of the blood lead test when screening children for lead poisoning. The erythrocyte protoporphyrin test is no longer acceptable as a screening test for lead poisoning. The screening blood lead test may be done by fingerstick or venous blood sample:

   a. Risk Assessment. All children from 6 to 72 months of age are considered at risk and must be screened. Beginning at six months of age and at each visit thereafter, the provider must discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure. (See appendices 13A and 13B of this handbook for a sample questionnaire.) Use of this questionnaire is optional.

   b. Determining Risk. – Risk is determined from the responses to the questions in the verbal risk assessment. Results must be documented.

   If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure, but must receive blood lead screening by blood lead test at 12 months of age and 24 months of age.

   If the answer to any question is positive, a child is considered high risk for high doses of lead exposure. A blood lead test must be obtained at the time a child is determined to be high risk.

   Subsequent verbal risk assessments can change a child's risk category. If as the result of a verbal risk assessment a previously low risk child is recategorized as high risk, that child must be given a blood lead test.

   c. Screening Blood Tests. – The term screening blood tests refers to blood tests for children who have not previously been tested for lead with a blood lead test or who have been previously tested and found not to have an elevated blood lead level. If a child is determined by the verbal risk assessment to be at:

      1. Low Risk – A screening blood lead test is required at 12 months of age and a second blood lead test at 24 months of age.

      2. High Risk – A blood lead test is required when a child is identified as being high risk, beginning at six months of age. If the initial blood lead test results are less than 10 micrograms per deciliter (ug/dL), a screening blood lead test is required at every visit prescribed in the HealthCheck periodicity schedule through 72 months of age, unless the child has already received a blood lead test within the last six months of the periodic visit.

C. OTHER BILLABLE HEALTHCHECK SERVICES

The following procedures should be performed when age, sex, race or other clinical indicators warrant further testing in addition to a comprehensive screening. Refer to Appendix 1 of this handbook for a list of allowable HealthCheck procedure codes, and to the HealthCheck Periodicity Table in Appendix 5 of this handbook for age appropriate test frequencies and further guidelines.

1. Performance of either Hematocrit or Hemoglobin test to screen for iron deficiency, anemia or other abnormalities. Either hematocrit or hemoglobin may be performed in a given screening. Reimbursement is limited to only one of these test procedures.

2. Urinalysis.

C. **OTHER BILLABLE HEALTHCHECK SERVICES** (continued)

3. Observation for pinworm.

4. Stool specimen for ova, parasites, and blood.

5. Urine culture.

6. Drug dependency screening.

7. Tuberculin Test. An annual intradermal (Mantoux) skin test using Purified Protein Derivative (PPD) is recommended for people of high risk populations, especially Southeast Asian immigrants. Additional testing may be done at the clinician's discretion.

8. Environmental Inspection (EI) for Lead Poisoning. EI may be covered with prior authorization. EI is a covered WMAP service when the child is shown to have lead poisoning, i.e., child has a veinous blood lead level > 19 µg/dL or two consecutive blood lead levels of 15-19 µg/dL done three months apart. The inspection must be of the child's home. The person doing the inspection must have received DHSS approved lead inspection training to be certified to provide this service. All three of these criteria must be met in order to receive prior authorization approval for this service.

   An agency must have certified staff to do EI. In order to be reimbursed by the WMAP, staff performing the inspection must have received Department of Health and Social Services approved lead inspection training and the agency must be a HealthCheck screening agency (provider type 66). Currently, many local public health agencies meet these criteria.

   EI of the child's home involves not only the identification of potential sources of high-dose exposure to lead, but also advising parents about identified and potential sources of lead and ways to reduce exposure. Once home owners are notified of the problem and have an opportunity to remedy the situation, a second EI should be conducted to assure that the problem is resolved. Additional information about aspects of the environmental assessment can be obtained from the CDC Guidelines on Lead Exposure ("Preventing Lead Poisoning in Young Children") and the prior authorization form in Appendix 22 of this handbook.

   Technical aspects of inspection include:

   - determining the most likely sources of high-dose exposure to lead;
   - investigating the child's home, giving special attention to painted surfaces, dust, soil, and water;
   - advising parents about identified and potential sources of lead and ways to reduce exposure;
   - notifying the property owner immediately that a child residing on the property has lead poisoning, emphasizing the importance of prompt abatement;
   - monitoring the effectiveness and timeliness of abatement procedures closely; and
   - coordinating environmental activities with those of other public health and social management agencies.

   Prior authorization for this service is obtained by sending a completed Prior Authorization Request Form (PA/RF) and a completed Prior Authorization for Environmental Inspection Form (PA/EI) to EDS. The PA/RF may be obtained from EDS. The PA/EI is in Appendix 22 of this handbook. EI is covered on a fee-for-service basis for all WMAP recipients, including recipients in WMAP-contracted managed care programs.

C. OTHER BILLABLE HEALTHCHECK SERVICES (continued)

Beginning March 1, 1995, you may obtain prior authorization for environmental lead inspections, electronically through the STAT PA system. Refer to Appendix 23 of this handbook for instructions on use of this electronic system.

Each prior authorization for lead inspection of a child's home to determine the source of lead poisoning will allow one initial inspection (W7083) and one follow-up inspection (W7084). Additionally, one visit by a nurse for education related to lead poisoning may be needed and should be billed with procedure code W7017.

9. Sickle Dex.
10. Pap Smear/Pelvic Exam. (***NOTE:*** These procedures may only be performed by or under the direct supervision of a physician, physician's assistant or nurse practitioner.)
11. Human Immunodeficiency Virus (HIV).
12. Individual screening components should be billed when less than a complete comprehensive screen is done.
13. Providers who receive vaccines through the VFC must bill for immunizations using the specific CPT codes listed in Appendix 1 of this handbook. Reimbursement is for the administration only, since providers receive the vaccine free through the VFC.

D. INTERPERIODIC VISIT

Interperiodic visits may be scheduled between regularly scheduled comprehensive screens. These medically necessary visits are to follow up on issues noted during a comprehensive screen. Examples include follow-up after finding low hemoglobin, nutrition concerns or elevated blood lead level.

In addition, interperiodic visits may be appropriate and can be requested by any individual inside or outside the formal health care system who feels there may be a physical, mental or psychosocial issue which requires additional evaluation. The scheduling of interperiodic visits shall be based on medical necessity.

Interperiodic visits are not to be billed if a child is seen for one or more components of a comprehensive screen, such as a hearing test and vision screen. In that case, the individual components performed should be billed.

In two situations you may bill for an interperiodic visit when a comprehensive screen has not previously been done. These are:

- when prior authorization has been granted for environmental lead inspection and an interperiodic visit for education related to lead poisoning (W7017) is billed; or
- when a child comes in for immunizations (W7013).

E. LABORATORY HANDLING FEE

A preparation or handling fee is allowed and may be reimbursed when billed by a HealthCheck provider for laboratory specimens sent to an outside lab. This occurs most frequently when a blood lead is drawn. If the sample is sent to an outside lab for analysis, the lab handling fee procedure code, not the blood lead procedure code, should be billed. Refer to Section IV of this handbook for billing procedures and limitations for lab handling fees, and to Appendix 1 of this handbook for allowable laboratory procedure codes.

F. HEALTHCHECK "OTHER SERVICES"

Introduction

Under HealthCheck, the WMAP will reimburse providers for other health, diagnostic and treatment services, which are medically necessary to correct or ameliorate defects and physical or mental illnesses and conditions discovered by the HealthCheck screening services. Services must be included under Title XIX of the Social Security Act, but may include services not otherwise covered by the WMAP.

HealthCheck "Other Services" always require a HealthCheck referral. In addition, HealthCheck "Other Services" always require prior authorization, except for dental sealants on first and second permanent molars. As with all Medical Assistance services, the WMAP has the authority to review the medical necessity of all requests, establish criteria for the provision of such services, and determine the amount, duration, and scope of services so long as the limitations are reasonable and maintain the preventive thrust of HealthCheck. Refer to Section III-B of this handbook for information on obtaining prior authorization for HealthCheck "Other Services".

Services Covered Under HealthCheck "Other Services"

The federal intent of coverage of HealthCheck Other Services is to expand Medical Assistance services provided to children. Wisconsin's Medical Assistance coverage is comprehensive, and includes most of the services allowed by Title XIX of the Social Security Act.

While it is not possible to identify all the services that may be requested under the "Other Services" benefit, the following list includes a sampling of services that may be requested under this benefit:

1. Child and adolescent mental health day treatment for recipients identified as severely emotionally disturbed;
2. Intensive in-home psychotherapy for children and adolescents identified as severely emotionally disturbed;
3. Medically necessary noncovered over-the-counter medications; and
4. Noncovered dental services.

NOTE: Services that are not proven to be safe and effective are not covered.

G. HEALTHCHECK REFERRALS

If the provider is unable to provide all the essential components of a comprehensive HealthCheck screen, the recipient must be referred to another certified HealthCheck provider for the remaining components of the screen.

The recipient must be referred for any needed follow-up care that cannot be provided at the time of screening, including mandatory referral for an annual dental examination if the recipient is not regularly receiving dental care. The recipient must be given a completed referral form when a referral is made. (Refer to Appendix 11 of this handbook for a sample HealthCheck Referral Form.) The referral form serves as the recipient's documentation of a HealthCheck referral for care and should be taken by the recipient to the referral appointment. Any necessary prior authorization forms must be completed by the provider of services, not the referring agency, although you may need to supply clinical information to the provider. For example, if iron supplements are required, the pharmacy will need the diagnosis, current hematocrit or hemoglobin, and planned length of treatment. Additional HealthCheck Referral forms can be obtained by submitting a written request to:

EDS
Attn: Claim Reorder
6406 Bridge Road
Madison, WI 53784-0003

G. HEALTHCHECK REFERRALS (continued)

When a referral to the WIC Supplemental Nutrition Program is made for pregnant women under age 21 and children under age 5, complete a WIC Referral Form (see Appendices 12a and 12b of this handbook). The WIC Referral Form should be given to the recipient for presentation to the WIC clinic.

For information on how to obtain the WIC or HealthCheck Referral forms, refer to Appendix 16 of this handbook.

Referrals should be considered for additional services (even if not covered by Medical Assistance), such as parent respite centers, child rearing classes, family planning services, AODA programs, adolescent health/sexuality education resources, Head Start programs, specialty treatment providers, high risk prenatal care, early intervention services, mental health programs, or developmental disabilities services. (Refer to Appendix 2a of this handbook for a listing of all appropriate referral/modifier codes). The referral process should make the recipient aware of the array of services available. It is also intended for discussing means of overcoming barriers to recipient follow-through.

To the extent possible, the screener should help the recipient resolve obstacles to accessing HealthCheck follow-up services (e.g., contact the case management agency or the county Department of Social Services for assistance in finding interpreter services or with transportation).

H. CHOOSING THE APPROPRIATE COMPONENTS FOR A PARTICULAR RECIPIENT

Not every exam component is needed for every recipient. Age, sex, race, sexual maturity, previous health problems and recent treatment will influence the recipient's risk status and the need for testing. For example, a recipient who comes for a screening, but has recently been certified to receive WIC, may not need a hematocrit test for anemia. Similarly, a hearing test is unnecessary for a recipient previously referred to an audiologist via a school screening exam. Providers should reference Sections II-B through II-D of this handbook for a complete description of the components of the HealthCheck screening. The HealthCheck Individual Health History, and the updating of this information at each visit, is designed to support the determination of necessary testing and must be a part of every HealthCheck exam.

To choose which examination components are appropriate for a given recipient and to suggest the optimal timing for periodic exams, refer to the Periodicity Table, which indicates recommended exam components for specific recipient ages (Appendix 5 of this handbook).

If some, but not all, components of a comprehensive screen are appropriate, only bill for those components performed. Refer to Appendices 1a and 1b of this handbook for a list of billable screening components.

I. ADOLESCENT HEALTH SCREENING COMPONENTS

Adolescent health visits should involve seeing the adolescent alone as well as with the parents. The adolescent should be assured of the confidentiality of the interview.

The Adolescent Review Form (see Appendix 9 of this handbook) will aid in conducting the adolescent screening, including information about sexuality, conception, contraception, and sexually transmitted diseases.

J. RESULTS OF THE SUCCESSFUL SCREENING

Following performance of the screening, test results must be explained to educate the recipient or parent about preventive measures that can be taken. Discuss the need for referred follow-up care (e.g., dentist) and schedule the next periodic examination when possible.

K. DIAGNOSIS AND TREATMENT

All appointments for any further diagnosis or treatment, as a result of the screening, must be scheduled within 60 days of the date of the HealthCheck screening. All WMAP services on a HealthCheck referral should be provided within six months of the screening date.

L. VACCINES FOR CHILDREN PROGRAM

In August 1993, Congress passed the Omnibus Budget Reconciliation Act creating the vaccines for Children (VFC) Program. This federal VFC program is intended to help raise childhood immunization levels in the United States. The VFC supplies free vaccine to private and public health care providers who administer vaccines to eligible children. Eligible children under the VFC program include, among other groups, all WMAP-eligible children.

The Department of Health & Social Services, Bureau of Public Health, ships the vaccines. Vaccines are shipped to the address included on the provider profile form which is to be completed by one provider or clinic manager for the entire practice. Vaccines are shipped on a request basis to providers from the state distribution center. Appendix 20 of this handbook contains a copy of the order form that must be used.

Providers must enroll to receive vaccines through the VFC program. All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are provided for eligible children. Appendix 21 of this handbook contains a list of ACIP recommendations for immunizations.

Participation in the Vaccines for Children Program

Enrollment

- Complete the two Center for Disease Control forms (one set of forms per shipping site, not per provider):

  1. The "Provider Enrollment" form indicates agreement with the components of the VFC program. This form is completed only once and must be signed by a physician.

  2. The "Provider Profile" form estimates the number of children vaccinated in your practice annually and the proportion likely to qualify for VFC. This profile is used to establish maximum order levels per shipping site. The form is updated annually and can be updated more frequently if your needs change.

- Send the enrollment and profile forms to the State Immunization Program.

Ordering and Shipping

- Order forms #DOH 1099 should be sent to the Wisconsin Immunization program. Forms may be obtained from:

  Wisconsin Immunization Program
  1 W. Wilson Street
  Post Office Box 309
  Madison, WI 53701

- Vaccines must be ordered. There will be no automatic shipments.

- VVP vaccine may be used for the VFC program.

- Reorder vaccine when your VFC inventory is down to a one-month supply.

- Vaccines will be provided to you within two weeks.

Accounting and Storage

- No state report of vaccine usage is required.

- VFC vaccines must be kept with other vaccines. Use the oldest unexpired vaccine first.

- Establish an in-clinic tracking system to determine when to reorder VFC vaccine.

L. VACCINES FOR CHILDREN PROGRAM (continued)

Documentation Requirements

- Screen parent or guardian for eligibility. The response does not have to be verified.
- Maintain a record of screening on eligible children receiving VFC vaccines.

Billing for Services

The procedure for billing vaccinations to the WMAP will not change. All HealthCheck providers must bill the appropriate CPT code for immunizations given.

- Bill the appropriate CPT code(s) for the vaccine(s) given. This coding will reimburse the administration fee; and
- Bill the appropriate comprehensive screen, office visit or interperiodic screen charge to reflect the level of medical service provided at the time of the vaccination. A brief visit should be billed if the child is in for the immunization only.

M. NONCOVERED HEALTHCHECK SERVICES

Noncovered HealthCheck services include any service not specifically cited in Section II-B through II-F of this handbook as a covered component of a HealthCheck screening examination. The following services are not covered by the WMAP.

1. Comprehensive screenings in excess of periodicity limitations.
2. Pap smears and pelvic exams not performed by or under the direct supervision of a physician, physician assistant, or nurse.
3. HealthCheck screening components provided to an HMO enrollee by a non-HMO affiliated provider.
4. Any service provided to a recipient who is not eligible for Medical Assistance on the date of service.

A. PRIOR AUTHORIZATION

HealthCheck screenings do not require prior authorization. However, services which result from a HealthCheck referral are subject to all applicable prior authorization requirements.

B. PRIOR AUTHORIZATION FOR HEALTHCHECK "OTHER SERVICES"

Providers performing HealthCheck "Other Services" must submit a prior authorization request to EDS within 365 days of the HealthCheck examination during which the need for the service or item was determined. (Refer to Section II-F of this handbook for a description of HealthCheck "Other Services".)

The prior authorization request must be submitted by the provider who will provide the service within 365 days of a HealthCheck screening, and must include the following components:

1. A completed prior authorization form and appropriate attachment for the service to be provided. Do not include the CPT-4 code and type of service code for the service being requested. This information will be completed by the WMAP Medical Consultant. Refer to Appendix 14 of Part A of the WMAP Handbook for a list of required prior authorization forms for each type of provider, and to provider type specific handbooks and bulletins for instructions on form completion. Prior authorization request forms can be obtained by submitting a written request to:

   EDS
   Attn: Claim Reorder
   6406 Bridge Road
   Madison, WI 53784-0003

2. A copy of the completed and signed documentation demonstrating that a HealthCheck screen has taken place within the last 365 days.

3. On the prior authorization or HealthCheck referral form, or in the prior authorization attachment, the provider must include the following information:

   a. The medical necessity of the service;

   b. Information about the service itself;

   c. If the provider is not certified or eligible for certification with the WMAP, information about the provider's qualifications, and why the provider is qualified to deliver that particular service; and

   d. Any other information that will help define the recipient's need, the provider's skills, and the type of service or item to be provided.

For enrollees in WMAP-contracted managed care program(s), providers must submit a request to the managed care programs except for environmental inspections which are fee-for-service. Procedures for this submission must be obtained from the managed care program. If the managed care program denies a request, the recipient may appeal the decision utilizing the managed care program appeal process.

C. PRIOR AUTHORIZATION FOR ENVIRONMENTAL ASSESSMENTS FOR LEAD POISONING

To receive prior authorization, send a completed Prior Authorization Request Form (PA/RF) and a completed Prior Authorization for Environmental Inspection Form (PA/EI) to EDS or submit your request electronically. Directions for electronic prior authorization requests are in Appendix 23 of this handbook. The PA/RF may be obtained from EDS. The PA/EI is in Appendix 22 of this handbook. Environmental inspection is covered on a fee-for-service basis for all WMAP recipients, including recipients in WMAP-contracted managed care programs.

D. PRIOR AUTHORIZATION FOR HEALTHCHECK "OTHER SERVICES" (continued)

Each prior authorization for lead inspection of a child's home for the source of lead poisoning will allow one initial inspection (W7083) and one follow-up inspection (W7084). Additionally, one interperiodic visit by a nurse for education related to lead poisoning may be needed and is billed with procedure code W7017. (Procedure Code W7017 *does not* require prior authorization, but it is only covered when W7083 or W7084 is prior authorized.)

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered by health insurance, the WMAP reimburses that portion of the allowable cost remaining after all other third party sources have been exhausted. Refer to Section IX-D of the WMAP Part A Provider Handbook for more detailed information on services requiring billing to health insurance, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Since Medicare does not cover HealthCheck services, claims for HealthCheck services provided to dual-entitlees need not be billed to Medicare prior to billing Medical Assistance.

C. MEDICARE QMB-ONLY

QMB-only recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does not cover HealthCheck services, claims submitted for QMB-only recipients are denied.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient.

The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount will automatically be deducted from the payment allowed by the WMAP. Refer to Section I-C of this handbook for additional information on recipient copayment.

E. BILLING LIMITATIONS APPLICABLE TO LABORATORY PROCEDURES

If a HealthCheck provider obtains a specimen and refers it to an outside laboratory for analysis or interpretation, only the outside laboratory that performs the analysis and interpretation may be reimbursed for the complete procedure. The HealthCheck provider may only be reimbursed for a handling fee. It is not necessary to indicate the specific laboratory test performed on the claim form.

If a HealthCheck provider performs both the professional and technical components of a laboratory test, the HealthCheck provider may be reimbursed for the complete procedure. In this instance, a handling fee will not be paid.

Additional limitations on billing handling fees are as follows:

1. One lab handling fee is paid to a HealthCheck provider per recipient, per outside laboratory, per date of service, regardless of the number of specimens sent to the laboratory.

2. When billing handling fees for specimens sent to two or more laboratories for one recipient on the same date of service, indicate the number of laboratories in element 24G and the total charges in element 24F of the HCFA 1500 claim form. The name of the laboratory does not need to be indicated on the claim form; however, this information must be documented in the provider's records.

3. A lab handling fee is paid only when "yes" is indicated for outside laboratory in element 20 of the HCFA 1500 claim form.

4. The date of service for a lab handling fee must be the date that the specimen is taken.

Clinical interpretations of laboratory tests are not separately billable, since interpretations are reimbursed within the payment for the recipient's visit.

F. VACCINES

All vaccines must be billed using the appropriate CPT procedure code listed in Appendix 1 of this handbook. The immunization administration fee (W7011) is not reimbursable for dates of service on or after October 1, 1994. Refer to Section II-L, Vaccines for Children of this handbook for additional information.

G. PROCEDURE CODES OPTIONS

For claims received by the fiscal agent between February 15 and June 30, 1995 you may bill comprehensive HealthCheck Screens by using:

- W7000, the local HCPCS code, with claim sort indicator "H" as described in Section IV-H below; or
- the appropriate preventive medicine Common Procedural Code Terminology (CPT) with claim sort indicator "P" and a HealthCheck modifier. When you use CPT codes, all HealthCheck services must be billed with a "P" claim sort indicator, not just the comprehensive screen. This billing is described in Section IV-I below.

Do not use parts of each billing method or bill both ways. Doing this results in claim denials or incorrect reimbursement.

This transition period allows providers to make the changeover at their convenience.

H. BILLING LOCAL PROCEDURE CODES WITH CLAIM SORT INDICATOR "H"

For claims received by the fiscal agent on or before June 30, 1995, you may continue to bill HealthCheck services exactly as you currently bill, as noted in Section G above, except fewer procedure codes are allowable as partial screening components. This method of billing HealthCheck services will not be valid for claims received by the fiscal agent after June 30, 1995.

If you choose to continue to bill comprehensive HealthCheck screens with W7000 during the transition period, follow the 1994 billing procedures and the directions below.

The only change in billing is the list of partial screening procedure codes allowed.

Valid Screening Components

Effective for dates of service on or after February 15, 1995, the only valid partial screening component codes are:

- W7002 - Vision Test
- W7003 - Hearing Test
- W7009 - Oral Assessment
- W7010 - HealthCheck Pelvic Exam

Additional Billing Information in Related Appendices

Appendix 1a lists all allowable HealthCheck local codes.

Appendix 1 lists all allowable HealthCheck lab and immunization procedure codes.

Appendix 4a is a sample HCFA-1500 billing form showing claim sort indicator "H".

Appendix 18a is a table which shows valid modifier codes, type of service (TOS) codes, and place of service (POS) codes for all allowable HealthCheck local codes. Note that modifiers should not be billed with lab or immunization codes.

I. BILLING CPT CODES WITH CLAIM SORT INDICATOR "P"

For claims received by the fiscal agent on and after February 15, 1995, you may bill comprehensive HealthCheck screens using the appropriate CPT code, the "P" claim sort indicator as noted in Section G above, and a new HealthCheck modifier. For claims received by the fiscal agent after June 30, 1995, you must bill comprehensive screens this way.

When you switch to claim sort indicator "P", follow the directions below.

I. **BILLING CPT CODES WITH CLAIM SORT INDICATOR "P"** (continued)

Make all the billing changes at the same time, (i.e., use CPT codes, "P" claim sort indicator and the appropriate new modifier). All HealthCheck services must then be billed with a "P" claim sort indicator

Procedure Codes

The following Preventive Medicine CPT codes will be used with a new HealthCheck modifier to bill comprehensive HealthCheck screens: 99381-99385 and 99391-99395. These codes are age specific. Refer to Appendix 1b of this handbook for definitions of the codes.

Partial screening components and interperiodic visits continue to be billed with the current local codes, but do not require a modifier.

Modifiers Indicating a Referral

Modifiers must always be used when billing a comprehensive HealthCheck screen. These modifiers indicate:

- a medical referral;
- a vision and/or hearing referral; or
- no referral.

If both the vision/hearing, and medical referral code apply, use the medical referral code.

Two new sets of modifiers are available depending on the type of provider .

HealthCheck Nursing Agencies

"HA" (medical referral), "HB" (vision or hearing referral), and "HC" (no referral) are used by HealthCheck nursing agencies only (provider type 66).

Physicians, Physician Assistants, Independent Nurse Practitioners

"MR" (medical referral),"VH" (vision or hearing referral), and "NO" (no referral) are used by physicians, physician assistants, and independent nurse practitioners. (As always, a performing provider must also be included for this group of providers). Never bill other modifiers such as "PD" or HPSA modifiers on the same claim detail as one with a HealthCheck modifier.

Refer to Appendix 2b of this handbook for more detailed descriptions of the modifiers.

Only the comprehensive screening codes require a modifier when billing CPT codes. No modifier is required for screening components, interperiodic visits, or outreach procedures billed under the "P" claim sort indicator.

Inappropriate use of modifiers will result in claim denial or incorrect reimbursement.

Table of Allowable Codes

Appendix 18b is a table showing which modifiers, TOS and POS are valid with each procedure code when claim sort "P" is used.

Sample Claim Forms

Appendices 4d, 4e,and 4f are sample completed HCFA 1500 claim forms using the "P" claim sort indicator for HealthCheck Nursing Agencies.

Appendices 4b and 4c are samples of completed HCFA 1500 claim forms using the "P" claim sort indicator for Physicians, Physician Assistants and Independent Nurse Practitioners.

J. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as paper claims. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time.

Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

HealthCheck services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions can be found in Appendices 3 and 4a through 4f of this handbook. Physician services must be submitted on a separate claim form from HealthCheck services using the appropriate claim sort indicator for each type of claim.

HealthCheck services submitted on any paper form other than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of sources, including:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by the fiscal agent within 365 days from the date the service was rendered. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals can be found in Section IX of the WMAP Part A Provider Handbook.

K. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied.

K. FOLLOW-UP TO CLAIM SUBMISSION (continued)

Providers are advised that the fiscal agent will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.